Medicare Supplement Insurance
-
- Regulatory Framework

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Purpose of today's presentation:

- Outline general regulatory framework
- Explain Department's role and authority, particularly with respect to rates
- Answer questions

What is and what is not Medigap?

- Medicare Supplement Insurance (a.k.a. Medigap) is a health insurance sold by private insurance companies that helps pay some of the health costs not covered by the Medicare. Policies have standard benefits (there are 12 different plans A through L). No duplication of benefits is allowed.
- Medicare Advantage, employer provided retirement health benefits, and prescription drug coverage provided under Medicare Part D, are not Medicare Supplement Insurance.

Consumer protection elements

- Standardized policy designs – currently twelve plans, A through L
- Open enrollment and guaranteed issue periods
- Open blocks – penalty for discontinuance
- Minimum loss ratios and rebates
- Restrictions on compensation arrangements – to discourage churning

Within each plan there are four possible types of policies

- Individual
- Group
- Individual Select
- Group Select

Select policies may condition benefit payments on the use of in-network providers

Rebates are calculated at the type level (possibly up to 48 separate rebate calculations for each state)

- Within each plan and type there can be up to five policy forms
  - Standard
  - With innovative benefits
  - Special marketing
  - Underwritten (substandard)
  - For those that qualify for Medicare on the basis of disability rather than age
- Experience of all these policy forms is combined for the purpose of rebate calculation

Currently there are three generations of the policies in the marketplace

- Pre-standardized plans
- 1990 standardized plans
- 2010 standardized plans

Experience of standardized plans (1990 and 2010 plans) is combined for rating purposes

Elements that enhance stability

Open enrollment and guaranteed issues

- Allows consumers to receive the "best" price without underwriting
- Keeps blocks open to new entrants avoiding rate spirals
- Insurer that discontinues a plan is barred from offering the same plan for a period of five years. Selling a block or changing rating methodology is considered discontinuance

First year commission cannot exceed by more than twice renewal commission in years two through six. This is to discourage churning

Rating structure

- Common rating variables include
  - Age
  - Gender
  - Family status
  - Tobacco use
  - Geographic area
  - Underwriting factor

- Of these, age, gender, and underwriting factor are probably the most significant.

Rating structure (cont.)

- If underwriting is used, the policy may be issued as “preferred” or “standard”
- Underwriting is not allowed for open enrollment or guaranteed issues – these are entitled to receive best available rates (“preferred rates”)
- One should choose wisely during the open enrolment – changing policies may be costly

Rating structure (cont.)

- Most policies are
  - Attained age – rates increase each year due to aging of the insured
  - Guaranteed renewable – insurer may revise rates for all insureds in the same class
- In most cases, premiums will increase each year to reflect
  - Rising health care cost
  - Aging of the policyholder
- Assuming 7% increase for medical inflation and 3% increase for aging, premium would double in about seven years

Department's rate authority

31A-22-620(3)(e) and 31A-22-620(4) give the Commissioner fairly broad authority with respect to rate review

- Establishing uniform loss ratio methodology
- Establishing approval of proposed rate increases
- Establishing a policy for rate increase hearings
- Establishing minimum loss ratio standards

Established rules follow the Federal requirements and NAIC recommendations

Rate oversight

- All Medicare Supplement rates have to be file for acceptance
- Rates and rate schedules have to be filed with the supporting documentation
- Demonstration of prospective compliance with the loss ratio standards is required
- Experience is to be reported annually by May 31
- Rebates are required if experience loss ratios are below benchmarks

Rate oversight (cont.)

- Loss ratio standard is 65% for individual and 75% for the group policies (true/pure medical loss ratio). Rate filings to demonstrate compliance on a prospective basis – requires projections, involves judgment
- Refund calculations are based on benchmark loss ratios adjusted for credibility. Refund by issuer, by state, by plan, and by type. Utah experience is usually not credible, resulting in no rebates

Rate oversight (cont.)

Selected factors used by the Department in the review

- Actual Utah experience
- National experience adjusted to Utah rates
- Relationship of Utah rates to nationwide rates
- Reasonableness of the assumptions (trend, mortality, lapse)
- Source of the assumptions
- Relativity of rates between different plans
- Size of the block of business

Rate oversight (cont.)

- Rates acceptance is based on
  - Whether the experience supports the assumptions used to develop the rates
  - Whether the overall rate structure is reasonable
  - Whether the rates are fair to Utah policyholders
  - The economic impact on the policyholders
  - The economic impact on the insurer
  - Timeliness of the rate requests

Rate oversight (cont.)

- Other factors that may weigh on rates acceptance
  - Rebates, if any, paid in other states
  - Relationship of rates to the rest of the marketplace
  - Number of new entrants to the plan in recent years
  - Target/pricing loss ratio in past years filings

Questions?

Should you have any additional questions, you can contact me directly at 801-537-9289 or at tserbinowski@utah.gov